Articles

Cancer Insurance Policies in Japan and the United States

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Cancer care in the United States often results in financial hardship for patients and their families. Standard health insurance covers most medical costs, but nonmedical costs (such as lost wages, deductibles, copayments, and travel to and from caregivers) are paid out of pocket. Over the course of treatment, these costs can become substantial. Insurance companies have addressed the burden of these out-of-pocket costs by offering supplemental cancer insurance policies that, upon diagnosis of cancer, pay cash benefits for items that usually require out-of-pocket expenditures and are distinct from reimbursements made by traditional health insurance. Limitations associated with managed care have fostered increased consumer awareness and interest in the United States for cancer insurance and its ability to defray treatment expenditures that usually require out-of-pocket payments. Marketing campaigns are becoming more aggressive, and the number of cancer insurance policies sold has been steadily rising. While cancer insurance is only recently gaining popularity in the United States, it has been a successful product in Japan for over twenty years. In Japan, approximately one-quarter of the population own cancer insurance, and ten-year retention rates are estimated at 75%. As a result, individuals are afforded good access to nonmedical cancer services. Understanding the factors that led to the success of cancer insurance in Japan may assist policymakers in evaluating cancer insurance policies as they become more prevalent in the United States.

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The financial burden of cancer in the United States can be devastating to patients and family members; in 1997 alone, it accounted for $35 billion in direct medical costs, $12 billion in indirect medical costs, and $57 billion in mortality costs.[1] Although comprehensive health insurance covers most medical costs, it does not address the nonmedical costs associated with treatment, such as forgone wages, travel to and from medical care givers, deductibles and co-payments, experimental treatments, loss of income, and home care costs. These nonmedical costs are paid out-of-pocket and can be a financial hardship, even for patients who are treated on an outpatient basis.[2]

To fill the gap in coverage, many insurance companies offer supplemental insurance that pays cash benefits in addition to health insurance benefits for persons who are diagnosed with cancer. Companies offering supplemental insurance in the United States, Canada, and the United Kingdom are all seeing increased consumer interest in their products, whereas in Japan, cancer insurance has been well established for more than 20 years (L. Koco, "Critical Illness Policies Are Selling Well in UK," *National Underwriter*, April 19, 1996, p 21). Understanding the factors that have made cancer insurance a success in Japan may assist policy makers in evaluating cancer insurance policies in the United States.

Health Status in Japan

The Japanese population is widely regarded as one of the healthiest in the world, with a life expectancy of 76 years for men and 83 years for women, the highest of any industrialized nation.[3–6] The prevalence of cancer has increased rapidly since the 1950s, and cancer is currently the number 1 cause of death.[7,8] A major factor in the health of the Japanese population is considered to be their low-fat diet of mainly fish and vegetables. As

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Japan's economic prosperity has grown, however, the major causes of death, as in the United States, are related to behavioral factors. Japan has adopted western penchants for red meat and cigarettes, with a 63% smoking rate among Japanese men. These trends may explain why cancer has become so prevalent in contemporary Japan. It is predicted that by 2000, the rate of cancer-related deaths for men will be 229.1 per 100,000 versus 100.2 per 100,000 for women, rates that are similar to those in the United States today.[1,7,8] Stomach cancer has been the most common cancer for both men and women, but its incidence has been in steady decline, whereas the incidence of cancer of the lungs, colon, pancreas, biliary tract, breasts, and liver is on the rise.[7,8] Like that of western countries, Japan's population is rapidly aging, and the increased incidence in cancer deaths is especially apparent among the older population. It is estimated that by 2000, 60.6% of all cancer deaths will occur in persons older than 70 years.[8]

Cancer Care in Japan

Japanese medicine emphasizes early detection, based on government-subsidized screening programs.[9] The first programs, for stomach and cervical cancers, were begun almost 30 years ago. Lung and breast cancer screening programs were initiated in 1987, followed by screening for colorectal cancer in 1992. Screenees pay about 500 yen (US $4.59) for each screening test, and many companies provide mass screenings for various cancers at no charge to their employees. Screening for stomach and cervical cancers has shown high efficacy, and the five-year relative survival rate for patients with stomach cancer in Japan is about 40%.[9] Primary prevention measures, such as smoking-control policies, have yet to be implemented, and there is a widely held misperception among the Japanese that lung cancer can be solved by screening programs alone. This poses a unique moral hazard. The program may actually increase the incidence of disease through increased risk behavior. When combined with the widespread purchase of cancer insurance policies, which help to alleviate the fear of the disease, the question of increased risk behavior becomes more important.

Cancer care in Japan differs greatly from that currently practiced in most western countries.[10–12] Until recently, Japanese physicians rarely informed patients of their diagnosis, thinking that patients' knowledge of their disease contributes to a poor prognosis. Physicians often inform a family member of the diagnosis rather than the patient, an act consistent with the taboo nature of cancer in Japanese society. Treatment often focuses on rigorous drug regimens that are not available elsewhere in the world.[13] Cancer is discussed less often in Japan than in the United States, but both countries cite cancer as the most feared medical illness.[11,14] In a recent survey by the Life Insurance Culture Center, 90% of Japanese expressed fears about cancer (1996 Financial Analysts Briefing, American Family Life Assurance Company of Columbus [AFLAC], Columbus, Ga).

The initial hospital stay for a cancer patient in Japan averages 53.2 days, compared with 9.0 days in the United States.[15] Standard health insurance covers a ward room with about six beds. For an additional surcharge, referred to as the "room rate differential," a patient can stay in a private room. The room rate differential is paid out of pocket and ranges from 5,000 to 80,000 yen ($46 to $734) per day, depending on the hospital and the amenities included (1996 Financial Analysts Briefing, AFLAC). While in the hospital, it is common for patients to use monetary gifts as expressions of gratitude toward physicians. Monetary gifts are also used a means of access to eminent specialists (A. Hardman, "American Sumo," *Financial World*, August 3, 1993; 162[16]:42–43).

Private nursing care is another potentially large out-of-pocket expense associated with cancer treatment. The daily costs of private nursing care range from 10,000 to 15,000 yen ($92 to $138). Other out-of-pocket costs for cancer care include noncovered medicines, travel and family lodging expenses, and lost income. It is estimated that these expenses will cost a patient with cancer from 25,000 to 65,000 yen ($229 to $596) per day. Assuming a patient requests a private room and requires private nursing care, total daily out-of-pocket costs can range from 40,000 to 160,000 yen ($367 to $1,467). These costs do not include applicable co-payments for medical services, the maximum of which is 63,000 yen ($578) a month. When Japanese were surveyed about diseases they thought posed the greatest financial threat, 67% viewed cancer as the most expensive disease to treat (1996 Financial Analysts Briefing, AFLAC).

Japan's Health Insurance System

Health insurance for Japan's 127 million citizens is universal, and medical care in Japan accounts for 6.8% of the total gross national product, about half that of the United States.[4,16,17] Access to health care is considered a right, as stated in Article 25 of the Japanese constitution: "In all spheres of life, the state shall use its endeavors for the promotion and extension of social welfare and security, and of public health." Japan's first step toward universal health insurance came in 1922 with the establishment of the Health Insurance Law (*Kenpo-ho*), which structured health insurance in companies. This law was influenced by the bismarckian philosophy that healthier workers lead to higher productivity, which in turn leads to better military capacity.[17] As the world economy tumbled following Black Friday in October 1929, malnutrition and infectious diseases spread rampantly through Japan's rural areas. The Japanese government, under pressure to provide health insurance to the self-employed, especially farmers, enacted the National Health Insurance Law (*Kokuho*) in 1938. In the early 1950s, 5% of the Japanese population was expected to need some form of treatment for tuberculosis, about 30 million people were still uninsured, and universal health care became a priority.[16,17] In 1958 the National Health Insurance Law was amended, making coverage manda-

tory and universal for all Japanese, and in 1961 universal health care, or *Kai Hoken*, was enacted nationwide.

Japan's health insurance system is divided into three groups: Employees' Health Insurance, National Health Insurance, and Health and Medical Services.[17–19] Employees' Health Insurance covers employees of firms and has four subdivisions covering small and medium-sized companies, large companies, merchant marines, and public employees. Premiums for the Employees' Health Insurance are about 8% of income, with at least half being paid by the company. Insured persons have a 10% co-payment for all medical services, whereas dependents pay 20% for inpatient and 30% for outpatient treatment.

The National Health Insurance covers self-employed persons and retirees and is administered by local municipalities. Premiums are determined on the basis of a family's net worth and are paid solely by the insured. The premiums are generally higher (as much as double) than the Employees' Health Insurance, even though those enrolled in National Health Insurance have the lower average income of the two groups. Principal subscribers and their dependents pay a 30% co-payment for all medical care, whereas retirees pay 20%. To curb the expense of high-cost care, the government instituted a monthly cap of 63,000 yen for co-payments.

The Health and Medical Services system was designed to finance health care for Japanese older than 70 years. It is a pooling fund that collects from the other health insurance societies and is designed so that no one plan will shoulder a disproportionately heavy burden for the care of older persons. Older persons pay 700 yen ($6.42) a day for inpatient care and 1,000 yen ($9.17) a month for outpatient care, accounting for approximately 3% of the total funding for Health and Medical Services.[17] It is estimated, however, that Japanese older than 65 pay additional informal fees of 22,500 yen ($206) a month to allow for their lengthy hospital stays, which average 85.9 days.[12,20]

Cancer Insurance in Japan

The Japanese private insurance market is the largest in the world. The per capita life insurance in Japan, with a mean of $122,299 per person, is more than three times that of the second highest amount of $40,000 per person in the United States (1996 Financial Analysts Briefing, AFLAC). Japan's insurance industry is composed of three sectors. The first sector is the life insurance sector that pays a benefit for living needs or death. The second sector is the non-life insurance sector, which is similar to US property and casualty insurance. The third sector is for products such as cancer insurance that pay a benefit for specific diseases, accidents, and care.

The insurance industry in Japan is changing, and the first step toward deregulation began on April 1, 1996, with the enactment of the insurance business law. For the first time, life and non-life insurance companies in the first and second sectors have been allowed to enter each other's markets. Japan has agreed, however, to refrain from making radical changes in the third sector of the insurance industry, where cancer insurance policies exist, until the other sectors are substantially deregulated (D. P. Hamilton, "US and Japan End Insurance Dispute With Tokyo Conceding to Demands," *The Wall Street Journal*, December 16, 1996, p A2; S. WuDunn, "Accord Is Set on US Access to Japanese Insurance Market, *The New York Times*, December 16, 1996, p A7).

Cancer insurance policies were introduced in Japan in the 1970s when AFLAC of Columbus, Georgia, entered the Japanese market. It had prepared for four years to obtain a license and was granted one in 1974 by the Japanese Ministry of Finance, which was under political pressure to open up the insurance market to foreign competition (1995 Annual Report, AFLAC, pp 27–28). At the time, AFLAC was only the second foreign company licensed in Japan, and their main product, cancer insurance, was not competing directly with Japanese companies. It was given an initial four-year government-granted monopoly, which subsequently was extended another four years.

At the time of AFLAC's licensure, the incidence of cancer deaths in Japan was increasing rapidly, and cancer was the number 2 cause of death. The Japanese have for years been more worried about cancer than other diseases, and there was a strong market for cancer insurance policies. The AFLAC product was affordable, and sales were high. Although their monopoly expired in 1982, AFLAC currently insures about a fifth of the Japanese population, holding a 90% share of the cancer insurance market (1996 Financial Analysts Briefing, AFLAC). The company is now ranked 186th on the Fortune 500 list, mainly due to their Japanese operations, which account for 85% of their revenues (AFLAC's 1995 Annual Report, pp 27–28).

This company offers its Japanese cancer product primarily through companies, or corporate agencies; employees who purchase the product have the premium automatically deducted from their payroll. More than 47,000 corporations offer the product to employees through their payroll deductions. The penetration rate of AFLAC in large companies with 1,000 or more workers is 31%, whereas that in small companies with less than 100 workers is 18%.

Are Cancer Insurance Policies Needed in the United States?

Many of the forces that led to the successful sale of supplemental cancer policies in Japan are developing in the United States. In the 1970s and 1980s, cancer insurance policies were considered to be redundant or nonessential. Basic group insurance policies had co-payments as low as 10%, which have increased to 20% or more for persons who maintain fee-for-service health insurance plans or point-of-service options. As employers cut back on the health insurance benefits offered to employees, they are looking toward supplemental pro-

grams, such as cancer insurance, to offset some of the changes in coverage.

As in Japan, cancer incidence rates and cancer-related costs continue to increase steadily as the population ages. It was estimated that more than 1.3 million US persons would be diagnosed with a new cancer other than skin cancer in 1997. Medical care for cancer accounted for $35 billion of the $1 trillion in US health expenses in 1996.[1] Out-of-pocket and nonmedical expenditures for patients with newly diagnosed cancer, especially working-age adults, have a serious adverse affect on entire families. Experimental treatments are generally not covered or only partially covered. Cancer patients who live in rural areas face extensive travel costs. People living alone may need non-nursing help with activities of daily living, and up to a third of seriously ill patients with cancer, who receive care in an extensive care unit, have been reported to lose most of their savings during their illness.[21]

Among less severely ill cancer patients, nonmedical costs of several thousand dollars per year are typical, with approximately 45% of nonmedical costs being for out-of-pocket expenditures such as transportation and food and 55% for lost wages.[2] With the rapid trend in health care in the United States toward managed care and managed costs, nonmedical costs associated with cancer are likely to increase. Two recent surveys of the general population reported that 18% to 19% of Americans have problems paying their medical bills, with the percentage of those covered by health insurance reported at 75% and 81%, respectively.[22,23] Finally, as treatment options offered by managed care organizations become more limited, such as the refusal of reimbursement for lung cancer chemotherapy or high-dose chemotherapy for breast cancer, gaps in coverage become more apparent, creating opportunities for supplemental insurers to market cancer insurance policies (M. P. Schwartz, "Opportunities in Reform for Supplemental Insurers," *National Underwriter*, May 9, 1994; pp 2, 20).

History of Cancer Insurance Policies in the United States

Cancer insurance has been sold in the United States for years, and these policies have been the subject of a wide range of objections. In the 1970s and 1980s, they were criticized because of marketing and sales tactics that sometimes took advantage of consumers. In a 1978 survey, the House Committee on Aging found that 72% of state insurance commissioners thought that fear tactics were used to sell these policies, whereas 52% of all commissioners thought that the policies had limited economic value. State regulations were instituted to limit questionable marketing approaches of insurance companies. A 1981 study by the House Committee on Aging reported that fewer than 40% of cancer insurance premiums were paid out as benefits compared with the industry standard at that time of 80% for health insurance policies.[24]

As a result of the recent changes in health care delivery, the US health insurance system is experiencing an increased interest in cancer insurance policies, with cancer policies in 1994 covering 10.4 million insurers (L. Koco, "Critical Illness Policies Are Selling Well in UK," *National Underwiter*, April 29, 1996, p 21; "Limited Benefit Insurance: Palliative or Panacea?" *The Chicago Tribune*, February 25, 1996, business section, p 3; N. A. Jeffrey, "Your Money Matters: 'Dreaded-Disease' Policies Rise, But Some Say They're No Cure," *The Wall Street Journal*, February 21, 1996, p C1). Little effort has been made by managed care organizations to reduce co-payments or assist with out-of-pocket costs such as travel or lost time from work, and there are increasing restrictions on the type and frequency of care that can be provided. Companies marketing cancer insurance use these managed care trends to their advantage by informing the public of the possibility of increased out-of-pocket expenses if the highest level of care is to be maintained in the event of cancer.

Most cancer insurance policies reimburse as specific events occur, such as for each day in a hospital, surgical procedures, outpatient treatments, nursing services, transportation, hospice care, physician visits, and prosthetic devices. Only a few policies are limited to a one-time payout at the time of the diagnosis for cancer. The products are structured as indemnity policies, with payments made directly to insured persons or their assignee, regardless of whether they have existing health insurance in force. The policies are structured so that reimbursements are not affected by any payouts that result from traditional health insurance policies, which maintains their focus on assisting with both medical and nonmedical out-of-pocket costs.

Cancer insurance policies stand in contrast to other disease-specific and disability insurance policies, as well as Medicare supplements, which may assist with direct medical costs such as co-payments and deductibles, but do not assist with the large out-of-pocket nonmedical costs associated with cancer (for example, transportation, food, or lost wages). Policies such as those covering long-term care or disability can help with out-of-pocket costs (although specified to home care or nursing home care in long-term care policies). The problem with long-term care or disability policies is that, depending on the terms of the policy, a cancer patient is likely to have completed intensive treatment before the waiting period required to receive a benefit has been reached. Other disease-specific policies such as for heart attack or stroke may assist with out-of-pocket nonmedical costs, but are contrasted with cancer insurance because of the prevalence of cancer and the higher out-of-pocket costs associated with the disease.

About 26 companies market individual cancer insurance policies to employees, up from 12 in 1994, with the overwhelming majority of companies selling policies directly to large businesses for payroll deductions and through associations. A relatively newer product is offered by an additional 16 companies through direct marketing to individuals. The largest companies in these markets represent some of the more established compa-

Table 1.—*Characteristics of supplemental cancer insurance, terminal illness riders, accelerated death benefits, and disability income policies.*

	Supplemental Cancer Insurance	*Terminal Illness Rider*	*Accelerated Death Benefit*	*Disability Income*
When paid:.	Specific predefined	Less than 12 months to live,	Specific predefined	Unable to work
. . . . .	critical illness	with MD certification	critical illness	
How paid:	100% of face amount	% of face amount	% of face amount	Monthly income
Death Benefits:.	None	Payment of rider reduces death benefit	Payment of rider reduces death benefit	None
Continual Coverage:. . . .	Payment at time of critical events	Lump sum payment	Lump sum payment	Monthly, until return to work or death
Complexity of Claim . . . . Processing:	Requires submission of documents for each critical event	Relatively simple, narrow definition of terminal illness	Could be complex, need to meet definition	Significant and continually ongoing

nies in accident and health insurance. In addition to dominating the cancer insurance industry in Japan, AFLAC is the current industry leader in the United States. Marketing strategies for AFLAC in the United States are similar to those in Japan, with low marketing costs resulting from policies distributed through employee benefit programs and purchased through payroll deductions from workers' salaries. One type of payment option that is increasingly popular, the "cafeteria plan," allows premiums to be paid using the employees' pretax dollars. Payroll marketing is targeted toward working middle-class families.

A second cancer insurance provider, Capitol American, targets government and postal employees for payroll deduction. A third company, United American Insurance Company, primarily targets the Medicare population with a cancer policy program that began about a year ago. Its strategy is in line with its major product, "Medi-Gap" insurance policies, of which it is the largest provider in the United States. Finally, companies such as Mutual of Omaha and the Physicians' Mutual Insurance Company of Nebraska do direct marketing through mailings to individuals. In general, the companies that have more efficient marketing efforts have higher loss ratios and pay out more of their premiums to claimants.

The costs of the various cancer insurance policies are similar, averaging about $100 to $350 annually (for family coverage) per year for policies purchased through employers. For seniors, policies such as United American's can cost from $120 to $1,200 (depending on the level of desired benefits). Underwriting usually requires only that subscribers are cancer-free for a period of at least five years before purchasing the policy. Payouts are generally similar among the different products and are based on actuarial estimates of the incidence rates of cancer and the costs of cancer care. For example, AFLAC has had only three rate increases in the past 26 years. An average payout for a person who purchased a moderate cancer policy for $290 per year from AFLAC is $16,000—exclusive of wellness benefits for skin cancer—and is linked to trigger events described earlier (K. V. Spencer, written personal communication, September 17, 1996). For seniors who purchase the United American product, a policy costing $300 per year would pay out a one-time benefit of $10,000.

These policies continue to be controversial in 1998. Payout rates are regulated by state insurance commissions and are in the range of 60%, which is low compared with typical health insurance but is similar to the payout rate for other insurance policies such as term life. The difference in payout rates between the United States and Japan parallels the retention rates for these two countries, with retention rates of 75% or greater for ten-year periods in Japan, whereas only 25% of policyholders in the United States have carried the policy for ten years (S. Lohr, "Under the Wing of Japan Inc, A Fledgling Enterprise Soared," *The New York Times*, January 15, 1992, p A1). When persons change jobs, there is a high likelihood that the cancer insurance policy will lapse. Job turnover in the United States is frequent, although relatively uncommon in Japan. Most of the difference in payout rates between the two countries is related to the higher persistency rates in Japan—that is, Japanese policyholders are more likely to maintain their policies. Thus, the acquisition cost has to be absorbed within a smaller number of years for each individual policyholder.

The reasons for opposition to supplemental policies are diverse, but often include concerns about need, perceptions about value, and concerns that comprehensive health, terminal illness riders (sometimes called accelerated death benefits), and disability policies offer better value (Table 1). Terminal illness riders require that claimants have an expected life expectancy of 12 months or less, and coverage is a lump-sum payout, which reduces the future death benefits. Disability income generally requires that claimants submit medical documentation that they are no longer able to work, and monthly sums are paid until the policyholder is able to return to work. At the time of the diagnosis of cancer,

many persons have life expectancies of several years and often are either retired or able to continue working while receiving chemotherapy or radiation therapy.

There is also concern that widespread cancer insurance poses a moral hazard in the United States similar to that discussed earlier for Japan. Fear of cancer does play a role in the successful marketing of cancer insurance policies, and by alleviating that fear, cancer insurance may send the message that an increase in risk behavior is acceptable because the person is covered for the disease.

Supporters of cancer insurance policies argue that they are designed to be affordable supplements that fill gaps in comprehensive health insurance policies; they are primarily targeted to assisting persons and their families while treatment occurs, as opposed to providing support for loved ones if death should occur; and they are not linked to events such as losing time from work. In the past few years, cancer insurance companies appear to have turned the corner in terms of acceptance by key persons involved in oncology and in finance. Advisers and members of the board of insurance companies for cancer policies include not only leaders in academia and the public sector but also key persons of pediatric and adult cancer centers, who help to ensure that cancer policies are providing the most appropriate coverage.

Conclusions

Policy makers in the United States are beginning to look at Asian health systems for new approaches to health care financing, such as medical savings accounts in Singapore.[25] Despite cultural differences, the Japanese experience with cancer insurance policies may be useful for policy makers in the United States. In Japan, these policies have proved effective in supplementing government-subsidized universal health insurance by providing assistance with out-of-pocket expenses, an often-underappreciated aspect of cancer care. There is a potential for wider distribution of this product in the United States, especially among working persons who have limitations associated with managed care programs and face substantial out-of-pocket expenses. In addition, as technological advances such as genetic screening increase public awareness of the implications of cancer, there is likely to be increased interest in buying cancer-specific insurance to offset some of these risks.

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